



## Student Records Request and Parent Release Form

Student: \_\_\_\_\_ Date Requested: \_\_\_\_\_

### School Requesting Records:

Parkview Christian Academy  
201 W Center St  
Yorkville IL 60560  
Phone 630-553-5158  
Fax 630-480-4358  
Email [tdreisilker@parkviewchristian.net](mailto:tdreisilker@parkviewchristian.net)

### Current School:

\_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

Email: \_\_\_\_\_

I hereby give permission for you to release my child's school/therapeutic records, including all special education evaluations to Parkview Christian Academy, Yorkville, IL. All authorized staff and authorized written or personal communication between teachers and schools/therapeutic setting. I also give consent for the above- mentioned students permanent cumulative records including identifying information, academic records, standardized test results, attendance records, health and immunization records, birth certificate, vision and dental records, special education records, IEP's, etc. to be sent to Parkview Christian Academy.

Parent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_